Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 6-9-03.

I. DISPUTE

Whether there should be reimbursement for ambulatory surgical care facility charges.

II. FINDINGS

a. On July 2, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

b. On 11-25-02, the requestor billed $1,038.00 for outpatient services rendered at ___. The insurance carrier paid $397.80. The respondent reduced payment based upon, "M – The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D)."

c. The total amount in dispute is $640.20.

d. Based upon the UB-92, a lumbar / Sacral Interlaminar ESI fluoroscopy was performed on 11-25-02.

e. Section 413.011(b) of the Act states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

f. The requestor provided redacted EOBs that support payment of: billed $1338.00 – paid $1137.30 = $ 85% of amount billed minus 15% PPO discount = 100% for lumbar/sacral transforaminal ESI with fluoroscopy from ___; billed $1038.00 – paid $830.40 = 80% of amount billed minus 20% of PPO discount = 100% for lumbar facet Jt with fluoroscopy from Employers General; and billed $1338.00 – paid $1137.30 = 85% of amount billed for unknown procedure from Ace USA.

III. RATIONALE

The requestor submitted redacted EOBs that show payment was made of 100% of amount billed for ambulatory surgical care for similar principal procedure. According to Section 413.011(b), the fee charged was for similar treatment. Therefore, records support that charges and payment complied with Section 413.011(b).

IV. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for Ambulatory Surgical Care Facility Services in the amount of **$640.20.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **$640.20** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 20th day of January 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division